DOCUMENT RESUME

ED 445 468 EC 308 075

AUTHOR Robinson, Kristin E.

TITLE Expanding a Continuum of Care: Outcomes of a Partial Day Treatment Program.

INSTITUTION University of South Florida, Tampa. Louis de la Parte Florida Mental Health Inst.; University of South Florida, Tampa. Research and Training Center for Children's Mental Health.

SPONS AGENCY Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.; National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.

REPORT NO H133B90022

PUB DATE 1999-02-00

NOTE 4p.; In: The Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (12th, Tampa, FL, February 21-24, 1999).

AVAILABLE FROM For full text: http://www.fmhi.usf.edu/institute/pubs/bysubject.html.

PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.

DESCRIPTORS *Behavior Disorders; Children; Community Programs; *Cost Effectiveness; Elementary Secondary Education; *Emotional Disturbances; *Mental Health Programs; *Outcomes of Treatment; Parent Attitudes; Program Effectiveness; Residential Programs; *Transitional Programs

ABSTRACT

A study investigated the outcomes of the Acute Children's Extended Services (ACES) program, a Salt Lake City, Utah, program designed to help children with emotional and behavioral disabilities reintegrate into the community from inpatient or residential care. The study examined outcomes of the ACES program within four domains: access, clinical effectiveness, consumer satisfaction, and cost. Archival data were obtained for 99 children (ages 5-13) attending the ACES program during 1997-1998. Results found: (1) at the time of study, there was a 4-week waiting period for admission to the program, however, several wraparound services were available to waiting clients; (2) partial day treatment was effective in decreasing symptoms reported on a parent-completed checklist; (3) parents felt ACES procedures were fair and acceptable, and parents observed treatment gains, approved of the behavioral interventions, and were satisfied with the amount of time it took to access the program; and (4) the ACES program costs approximately $40 per day, with total cost for the average 13-week length of stay in partial day treatment ranging from $960 to $2,400. (CR)

Reproductions supplied by EDRS are the best that can be made from the original document.

ED 445 468

Expanding a Continuum of Care: Outcomes of a Partial Day Treatment Program

Kristin E. Robinson, Ph.D.
Children's Behavior Therapy Unit
668 S. 1300 E.
Salt Lake City, UT 84102
801/581-0194
E-mail krisr@vmh.com

Introduction

In 1991, the continuum of public mental health services for children in the Salt Lake City metropolitan area included inpatient, residential, day treatment, and outpatient treatment settings. Each of these treatment options presented a variety of barriers at the time. Service delivery at higher levels of restrictiveness was institutional and highly expensive. Outpatient clinics were overloaded, and monthly appointments were typical. Less-costly, community-based day treatment programs—seemingly the best of both worlds—had become bottlenecked with referrals. The Acute Children's Extended Services (ACES) was launched to examine whether an expanded continuum could ease cost and access barriers. ACES was designed to serve children on both ends of the referral continuum: helping children reintegrate into the community from inpatient or residential care, and as a diversion from these more restrictive placements. The present study examined outcomes of the ACES program within four domains: 1) Access, 2) Clinical Effectiveness, 3) Consumer Satisfaction, and 4) Cost.

Method

Participants

Archival data were obtained for 99 children attending the ACES program during 1997-1998. This sample was comprised of 70 boys, and 29 girls. The mean age of the outcome sample was 9.21 (*SD*= 2.20), with a range of 5-13 years old. The majority of referrals were Caucasian (82%). All families in the sample were receiving public financial support. The ACES program is supported under Medicaid capitation, and all children attending ACES are either unfunded or covered by Medicaid.

Eighty-seven percent of this sample met Utah state criteria for having severe emotional disturbance (SED). Over half (62%) of the children referred to ACES were diagnosed with Disruptive Behavior Disorders (Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder. Adjustment disorder and emotional disorders each comprised 11% of the sample. Other primary Axis I diagnoses included: Post-traumatic stress disorder, Bipolar Disorder, Psychosis NOS, and Pervasive Developmental Disorder.

Setting & Program Description

ACES is located at the Children's Behavior Therapy Unit (CBTU), a unit of Valley Mental Health, the largest community mental health center in Utah. The program has expanded several times, and now serves 50 children

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
✓ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

EC308075
BEST COPY AVAILABLE

concurrently. ACES utilizes a multidisciplinary team comprised of child psychiatrists, psychologists, and social workers. In addition to the standard individual, family, and group therapy, comprehensive services include medication management, 24-hour crisis services, psychological assessment, and parent training/support groups. Referral is enhanced by two critical components: a time-limited model, and an internal continuum offering 5-, 3-, and 2-days of treatment per week. A child may enter at any phase, and transition downward, for a total length of stay from 6 to 18 weeks. Transportation is provided to and from the program.

ACES operates within a behavioral treatment philosophy. Specific interventions include verbal praise, tangible reinforcers, individual behavior contracts, and brief time-out for severe noncompliance. Behavioral interventions have been shown to be significantly more successful in treating referred children as compared to other forms of psychotherapy (Weisz, Weiss, Morton, Granger, & Han, 1992). Behavioral interventions are also viewed as useful by practitioners (Kazdin, Siegel, & Bass, 1990), and rated as acceptable by parents (Reimers, Wacker, & Cooper, 1991) and teachers (Martens, Peterson, Witt, and Cirone, 1986).

Results & Discussion

Access. Access to services can be critical for the smooth transition of children between levels of care. At the time of this study, there was a 4-week waiting period for admission to the ACES program. However, several wraparound services were available to waiting clients. For example, all were enrolled in outpatient therapy at the time of referral, and a 24-hour crisis service was in place. The waiting list was prioritized daily, and children considered to be in acute crisis could be admitted within 48 hours.

Clinical Effectiveness. Clinical effectiveness was measured using the Youth Outcome Questionnaire (YOQ: Burlingame, Wells, Hoag, Hope, Nebeker, Konkel, McCollam, Peterson, Lambert, Latkowski, Ferre, & Reisinger, 1996). This 64-item, parent-completed checklist is designed to measure parent perceptions of treatment progress for children and adolescents ages 4-17. The clinical cutoff for the YOQ is a total score of 46, and a change of 13 points is considered to be significant. The YOQ was administered upon admission (Time 1) and transition/discharge (Time 2/3).

Analysis of group means indicated that partial day treatment was effective in decreasing symptoms reported on the YOQ (Figure 1). Several interesting factors arise when examining the YOQ scores by diagnosis (Figure 2). First, children with disruptive behavior disorders showed the most rapid change from admission to Time 2, then showed a slight decompensation at Time 3. Second, children with emotional disorders took longer to respond, but improved more at Time 3. Finally, children with adjustment disorders showed rapid and continued improvement in the program.

Consumer Satisfaction. A sample of 43 CBTU-developed consumer satisfaction surveys was obtained from parents whose children had participated in the ACES program. Results were positive overall, indicating that parents felt the ACES procedures were fair and acceptable. Parent responses indicated that parents observed treatment gains, approved of the behavioral interventions, and were satisfied with the amount of time it took to access the program.

Cost Comparisons. Program evaluation must take cost into consideration, and it is obvious that higher levels of care will require more resources. A full range of services is fiscally preferable, so treatment may be provided across time in the most efficient manner. The ACES program costs approximately $40 per day (3 hours). Total cost for the average 13-week length of stay in partial day treatment would range from $960 (attendance of 2-days per week) to $2,400 (5-day), a significant savings when compared against other treatment modalities.

Since its inception in 1991, ACES has progressed from serving 10 to 50 kids concurrently–over 300 families per year at the time of this study. Outcomes suggest that ACES is clinically effective, consumer-friendly, and cost-efficient. The program was effective in reducing parent-reported symptoms among children with a variety of behavioral and emotional disorders. Despite these promising results, several limitations exist within the present study. First, generalizability may be limited to clients having similar demographics of this sample—a majority of Caucasian boys, referred for disruptive behavior

problems, and all receiving Medicaid benefits. Second, most of the participants were exposed to several concurrent therapeutic interventions while attending the ACES program (e.g., outpatient individual therapy, sexual abuse group therapy, and respite care), which could confound present findings. Finally, maintenance of behavioral change is unclear, and follow-up studies are in progress.

References

Burlingame, G. M., Wells, M. G., Hoag, M. J., Hope, C.A., Nebeker, R. S., Konkel, K., McCollam, P., Peterson, G., Lambert, M. J., Latkowski, M., Ferre, R., & Reisinger, C.W. (1996). *Administration and scoring manual for the YOQ.* American Credentialing Services.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1990). Drawing on clinical practice to inform research on child and adolescent psychotherapy: Survey of practitioners. *Professional Psychology: Research and Practice, 21* (3), 189-198.

Martens, B. K., Peterson, R. L., Witt, J. C., & Cirone, S. (1986). Teacher perceptions of school-based interventions, *Exceptional Children, 53,* 213-223.

Reimers, T. M., Wacker, D. P., & Cooper, L. J. (1991). Evaluation of the acceptability of treatments for children's behavioral difficulties: Ratings by parents receiving services in an outpatient clinic. Child and Family Behavior Therapy, 13(2), 53-71.

Weisz, J. R., Weiss, B., Morton, T., Granger, D., & Han, S. (1992). *Meta-analysis of psychotherapy outcome research with children and adolescents.* Unpublished manuscript, University of California, Los Angeles.

Figure 1
Group Means

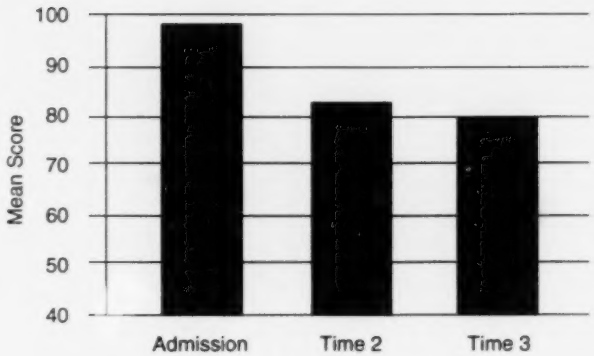

Figure 2
Group Means By Diagnosis